Texas Prescription Program
Texas Department of Public Safety

Fill in all the applicable information. Return completed form to:
Texas Prescription Program, P. O. Box 4087, Austin, TX 78773-0439 or fax to (512)424-5373
Online access available at: www.TexasPATX.com

REGISTRANT INFORMATION:

Title Name

Address (*must match registered address on file with DPS*) City State Zip

Work Telephone Fax Telephone

DPS Registration # DEA Registration # Board License #

SUBJECT OF REQUEST:

Last Name	**First Name**	**Middle Name**	**DOB (if a subject)**
Other Name Variations	***(List Below)***		
Last Name	**First Name**	**Middle Name**	**DOB (if a subject)**
Last Name	**First Name**	**Middle Name**	**DOB (if a subject)**

Identifying Numbers (DL, SSN, Other) **Registrant** (BD Lic#, DPS#, DEA#)

List all address possibilities:

Address	City	State	Zip
Address	City	State	Zip
Address	City	State	Zip

TYPE OF REQUEST *(please check one)*

☐ Prescribing History (practitioners only) ☐ Patient History
☐ Dispensing History (pharmacies only)

Date range: _____ *to* _____ ** most recent three months will be provided*

Purpose of Request: _____

I certify that the information is requested in compliance with 481.076 of the Texas Controlled Substances Act.

Original signature of REGISTRANT *(no stamps, copies, e-signature etc.)* Date